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ABSTRACT

This paper describes a community-based treatment model for people who are psychiatrically disabled and living outside an institutional setting. The background of the Community Rehabilitation Approach (CRA) is described including Training in Community Living (TCL) which involves: (1) assertively bringing treatment to the client directly in the environment (in vivo treatment) for four life areas, i.e., daily living, vocational concerns, leisure time, and social/interpersonal skills; and (2) the functional assessment of client skill levels in the four life areas. Individual components of the CRA model, i.e., case-finding, assessment, goal-setting and planning, implementation and evaluation, and treatment staff development, are also described. A case study is presented to illustrate the CRA process, and the assessment instrument, the Rehabilitation Rating Scale, is included. (MCF)

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A COMMUNITY BASED REHABILITATION PROGRAM FOR EMOTIONALLY DISTURBED CLIENTS

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ABSTRACT

This paper presents a treatment model for working with emotionally disturbed clients directly in the community in which they reside. The program model employs rehabilitation practices (i.e., action orientation, community service coordination and supportive counseling) and depends upon a professional interdisciplinary approach to meet total client needs in activities of daily living, leisure, vocational/school, family and social/interpersonal life areas.

The treatment program is based on identifying clients' functional skills and deficits and impacting upon them directly in the clients' environment. The program helps clients to effectively meet changes and challenges in their environments by teaching them the skills to do so directly where they will be needed.

An overview of the program including case finding, problem identification, functional assessment, treatment planning and program implementation is presented.

A COMMUNITY BASED REHABILITATION PROGRAM FOR
EMOTIONALLY DISTURBED CLIENTS

In the decades since the deinstitutionalization movement for chronically mentally ill people began in the United States, several community based programs have been instituted which are designed to provide after care and rehabilitation services to this diverse client group. These services have covered an entire range, including psychotherapeutic counseling in community mental health centers (Ozarin & Sharfstein, 1978), foster home placements (Fairweather, Sanders, Maynard & Cressler, 1966) and follow up with psychotropic drugs (Ozarin & Sharfstein, 1978). More recently, assertive approaches to community treatment (Stein, Test & Marx, 1975; Test & Stein, 1978), skills based rehabilitation approaches (Anthony, 1980) and club type support services (Barry, 1982) has been used with the noninstitutionalized CMI population. Research has shown that most of these approaches, especially the more recent ones, are effective to some degree in aiding these client's community adjustment and rehabilitation (Anthony, 1980; Barry, 1982; Margules & Anthony, 1976). The purpose of this paper is to describe a treatment model for people who are psychiatrically disabled and living outside an institutional setting. This model is unique in that it combines elements of several successful treatment modes, is a low cost alternative to more expensive treatments, and it takes a functional approach to client problems. It was designed for use in community mental health centers, but its principles and practices are readily transferable to other treatment settings including half-way houses, sheltered workshops and other rehabilitation technologies.

Background

The treatment model described here is referred to as the CRA method for community rehabilitation approach. It is philosophically and theoretically based on Anthony's (1980) principles of psychiatric rehabilitation, Test & Stein's (1978) assertiveness of treatment, and functional measurement of present client capacity to perform in several life areas which are critical to successful rehabilitation adjustment. I'll briefly describe these three components.

Psychiatric rehabilitation emphasizes skill building and health induction rather than symptomatology reduction as goals of treatment (Anthony, 1980). Health induction signifies the inducement of healthy living patterns into the client's life through a process of clear behavioral objectives, problem solving and extensive emotional support. Psychiatric rehabilitation is a skills based approach predicated on the assumption that helping people learn the skills required to live and work successful in a community is the most effective treatment mode to use with the chronic psychiatric population.

Stein et al. (1975) presented a method of treatment referred to as Training in Community Living (TCL) for the deinstitutionalized CMI population. They found that assertively bringing treatment to the client directly in the environment in which it was needed (known as in vivo treatment) greatly enhanced treatment effectiveness. For example, they found that cooking skills are best learned on one's own stove and cleaning skills in one's own room. This in vivo approach reduces the need to generalize learning from one situation to another, something known to be difficult for chronically mentally ill people to do

(Barbee, Barry & Micek, 1969). The TCL approach conceptualized activities of daily living, vocational concerns, leisure time, and social/ interpersonal skills as the four broad life areas in which CMI clients must be competent in order to live successfully in the community. Essentially, the TCL approach seeks to model, teach and induce competence in these four broad life areas through in vivo treatment and assertive following of clients in their environment. The regular taking of medications (as prescribed) and positive intensive emotional support are also emphasized.

The final background component of the Community Rehabilitation Approach rests upon a functional assessment of client skill levels in the four areas outlined in the Stein et al. model. A functional assessment is based upon what the client can or can't presently do that hinders successful community living. A tool was developed to aid functional assessment of client performance in the essential life areas. The purpose of this instrument was not so much to glean new client information as it was to reformulate information into a clearer, more concise package that both helper and client could use to aid their planning and goal setting strategies.

(Insert Figure 1)

In other words, the information gathered by the assessment instrument is more systematic and usable in terms of problem identification and subsequent problem solving for both counselor and client than if no formal assessment instrument were used. A perusal of the instrument will show that it synthesizes the three theoretical approaches used in the CRA model. It is based on skill building (psychiatric rehabilitation), it must be at least partially used in the client's

environment (training in community living), and it is based on functional assessment of client competencies. Extensive research is currently being performed on the scale to determine, among other things, its predictive validity and interrater reliability.

The Community Rehabilitation Approach (CRA)

The CRA model is predicated on the assumption that if given enough support and treatment psychiatrically disabled people can learn the necessary skills to live and work effectively in a community. Therefore, this model emphasizes intense, assertive in vivo treatment that concentrates on skill building and the effective use of community resources to aid long term adjustment. A systematic program of client adjustment follows the traditional rehabilitation format of case finding, assessment, goal setting and planning, treatment, evaluation and follow-up. I'll go over each area as it relates to the CRA method.

Case-finding

The case finding aspect of the CRA is relatively straightforward. It is usually reserved for those agency clients who have been repeatedly institutionalized for emotional/psychiatric reasons, are frequent "no-shows" for appointments, are poor at generalizing learning, and those who are seen as being the most severely involved with their illness. Case finding of appropriate individuals can usually be done during regular staff meetings.

Assessment

Assessment of client needs is at the very core of the program. The helper is required to go directly into the client's living and working

environment, and, using the assessment instrument begin to determine client strengths and skill deficits. Similarly, the helper will have to obtain information on client leisure and social interpersonal skills through an environmental assessment (when possible) and indepth client interviews. Interviews with significant others (i.e., employers, family, etc. when feasible) may also aid the assessment process. The helper's task is to rate the client along the dimensions on the functional rating scale and present the findings to the client. The findings tend to be more nonthreatening and concrete and they serve as a basis for discussion and goal planning. It also helps if both the client and the helper fill out the scale when possible to determine discrepancies in perception of needs. I must emphasize that the functional rating scale is merely a tool to aid the helper and client in their identification of client problem and strength areas and to serve as a departure point for program planning to build on strengths and alleviate deficits. It is not intended to be an absolute reckoning of the client's needs.

Goal Setting and Planning

After a thorough assessment is completed, the counselor and client should be more aware of client strengths and skills deficits that affect the ability to live in the community. Client and helper will then begin to set goals that will aim to ameliorate or at least significantly decrease those problem areas. A hierarchy of the problems to be worked on (based on client needs and abilities) is agreed upon by the counselor and client and clear operationalized goal statements are then written. These statements should be unambiguous, have definable steps, and clearly spelled out client reinforcers for reaching incremental and final goals.

It should identify the achiever (client), describe the skill expected of the achiever in observable terms, and specify the conditions under which the action is to occur. For example, a goal statement that fits this model could be, "The client will report to work on time every day for one month. If done each week, X reinforcer given. If done for the month, Y reinforcer given." This provides a method for treatment staff to help improve concrete client behaviors.

Implementation and Evaluation

After the goals have been identified and planning completed, the next step is to implement the program plans. It is the helper's job to monitor the client's progress and to evaluate whether the plans are being carried out. If not, the professional needs to look at the reinforcers, the assessment and plans themselves along with the client's environment to determine where problems may be originating.

If the planning, goal setting and actual treatments are successful for any specific problem, the counselor and client will then repeat the implementation and evaluation procedure with the problem area which was determined to be next on the client's hierarchy. Using this model, the client hopefully can progress through each identified problem area and build up the necessary skills to live successfully in the community.

Treatment Staff Development

Any community service model is fine in theory, but it also takes a committed treatment staff to initiate and carry out this type of programming. This CRA method relies on staff cooperation and sharing of resources to insure optimal client outcomes.

After the staff has been trained in the assessment and problem solving strategies used in the CRA, they are asked to cooperatively build a master list of community resources and contact persons that will be of potential use in getting clients integrated into a community. This strategy is important for building staff cohesiveness and for helping them to think in terms of the kinds of resources that are potentially helpful for psychiatrically disabled clients. This listing includes not only traditional services like sheltered workshops, State Division of Vocational Rehabilitation (DVR) and other agencies, but since this is a comprehensive treatment program, also takes into account a whole range of resouces that may not be usually thought of as a part of a treatment mileau. For example, this list may include the leisure time resources of sports groups, church activities, protection services like police and country sheriffs, alternative living quarters, as well as including resources in medical, vocational, transportation, educational, and other social service areas. Each staff member is required to research a specific area, find as many resources as possible, and bring that information back to the entire staff who then discusses the potential usefulness of each identified resource. This sort of strategy is especially important in communities where the pool of resources is likely to be small.

After community resource discovery and development has taken place, the staff members are ready to choose clients to place in the program. Since it is so intensive and time consuming, the number of client participants should be small (initially no more than one per staff). The clients chosen to participate (with their consent) should have the most intensive needs for adjustment and who have had poor success with

traditional adjustment approaches. In other words, your most challenging clients whom you think can be helped with an alternative approach to their problems.

Once the clients have been identified, the staff members will assess their behaviors, determine problem and strength areas, institute problem solving, goal setting and treatment strategies, assess progress and evaluate results. This is an ongoing process, but hopefully, the client will become less dependent upon the individualized intensity and reinforcement procedures, as his or her life becomes more rewarding and he/she begins to feel more like a competent adult.

Case Example

An example of this process applied to an individual will help illustrate the value of the CRA model of assessment based on functional skills and deficits.

Raymond is a 28 year old black male from rural North Carolina. He has a diagnosis of paranoid schizophrenia and is currently being treated at a community mental health center. Raymond has a long history of repeated hospitalizations and releases and has held several jobs for short times. He was living with his parents at the beginning of this treatment process, and was unemployed. He spent most of his time in his room, would miss his counseling appointments about half the time and made few social contacts.

David, his counselor at the mental health center, felt that Raymond would be a good candidate for the program, so he discussed it with him, and Raymond agreed to take part.

David then went to Raymond's home to begin the assessment process. He found that Raymond had problem deficits in his family environment that were not really clear from the counseling sessions and were potentially severe enough to cause problems. (Any problem that is severe enough can cause decompensation and rehabilitation failure.)

David was able to observe Raymond in his home environment and was also able to interview the family members in their home. David then contacted Raymond's latest former employer (with Raymond's consent) to help determine some functional problems connected with job performance. He was told that lateness and the inability to get along with others, along with smoking marijuana in the bathroom led to his termination. David was able to translate those problems into the relevant areas on the scale that concern job maintenance behaviors. This also told David that Raymond's vocational problems concerned keeping jobs, not getting them.

David's knowledge of Raymond helped him to determine leisure time activities and other social/interpersonal strengths and deficits. Watching Raymond interact with a variety of other people also aided David's assessment.

In their meeting subsequent to the assessment, Raymond and David sorted through this new look at the problems Raymond faced, and determined the hierarchy in which they were to be addressed. Raymond felt he was having a great deal of trouble at home and given his added understanding, David agreed. They agreed (through problem solving) that the best option was to place Raymond in a half-way house in a nearby city. This enabled Raymond to get out of the pathological home environment, and find an

atmosphere where he could work on his interpersonal and leisure skills. Goals were written to address these problem areas.

Vocationally, they agreed that Raymond needed some help with job sustention skills. David and Raymond again met with his former employer who agreed to rehire Raymond under the guise of the program. It was agreed that Raymond would be under contract to: (1) appear at work on time (first weekly, then monthly) and (2) not use any unprescribed controlled substances before or during work.

He was to receive a weekly bonus of $5.00 from the employer for every week he fulfilled this contact and a $10.00 bonus if he did it for a month (money was reinforcing to him).

If he failed to fulfill his contract more than twice within the month he would be terminated. The contract was renegotiated after the month was over. He made three perfect weeks, and was late twice during one week of the first month.

David made frequent visits to the worksite and was also involved in the halfway house transition time for Raymond.

The closer contact and functional assessment that was done with Raymond really helped. A fresh look at his problem areas afforded a way to begin again with him and in his case, it was successful. He is now living in a 3/4 way house and has maintained his job without special reinforcers for about nine months.

The CRA method can't be used for everyone, but for those really difficult psychiatrically disabled clients with whom nothing seems to work, it represents an alternative course with potential for success.

[1]This scale is the latest draft of the functional capacities instrument. Extensive research is currently being performed on it and the author welcomes those who are interested in using the scale for research purposes to contact him at:

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REHABILITATION RATING SCALE

Date: _____

Name: _____ Rater: _____

A. Daily Living Skills/Competency

	0	1.	2.	3.	4.
1. PERSONAL APPEARANCE					
personal cleanliness					
hair grooming					
body odor					
cleanliness of clothes					
cleanliness of mouth					
body weight					
other physical/sensory/ disabilities (e.g., blindness, amputations, specify)					
other (specify)					
2. FINANCIAL SKILLS					
ability to determine (organize) a personal budget					
spending patterns					
ability to keep to a personal budget					
other (specify)					

0 - No information
1 - Problem (or skill deficit) severe enough to require immediate attention
2 - Problem (or skill deficit) in client's life that does not require immediate attention
3 - Passable (not a problem) aspect of client's life
4 - Positive aspect of client's life

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		0	1.	2.	3.	4.
3.	TELEPHONE SKILLS					
	answers telephone					
	exchanges information with other party					
	uses phone book					
	other (specify)					
4.	PHYSICAL HEALTH					
	seeks medical attention (when needed)					
	takes medication as prescribed					
	current state of physical health					
	exertional capacity					
	other (specify)					
5.	COGNITIVE LEARNING ABILITY					
	learns tasks of three steps or less					
	learns tasks of more than three steps					
	able to break tasks into component parts					
	generates alternative solutions to problems					
	chooses workable solutions to problems					
	persistence in task completion					
	reads at functionally literate level					
	writes at functionally literate level					

		0	1.	2.	3.	4.
5.	COGNITIVE LEARNING ABILITY (continued)					
	perception of disability					
	develops achievable nonvocational goals					
	other (specify)					
B.	VOCATIONAL					
1.	VOCATIONAL GOALS					
	states positive orientation toward employment					
	participation in program activities oriented toward employment					
	has clear vocational goal					
	has achievable vocational goal					
	knows personal vocational assets					
	knows personal vocational limitations					
	other (specify)					
2.	JOB-SEEKING BEHAVIORS					
	persistent in job seeking					
	uses available job lead resources					
	other (specify)					
3.	INTERVIEWING SKILLS					
	expresses enthusiasm toward work					
	maintains eye contact					
	emphasizes personal vocational assets					

		0	1.	2.	3.	4.
3.	INTERVIEWING SKILLS (continued)					
	speaks clearly in interview					
	asks for relevant information (e.g. wages, hours, etc)					
	maintains affect appropriate for interview					
	other (specify)					
4.	WORK HISTORY					
	continuity of previous jobs (focus)					
	number of previous jobs					
	length of tenure on previous jobs					
	other (specify)					
5.	EDUCATIONAL HISTORY					
	academic training (specify highest level achieved i.e. H.S., G.E.D., B.S.)					
	vocational training (specify if any)					
	educational background related to vocational goal					
	existing available training possibilities					
	other (specify)					
6.	TRANSPORTATION					
	able to use public transportation					
	availability of public transportation					

	0	1.	2.	3.	4.
6. TRANSPORTATION (continued)					
posesession of valid drivers license					
able to regularly drive					
access to transportation on a regular basis					
other (specify)					
7. JOB MAINTENANCE BEHAVIORS					
attends work (or related activities) regularly (i.e. absent < twice monthly)					
reports on time regularly (i.e. late < twice monthly)					
when interacting with job superiors:					
a. asks relevant questions					
b. clarifies tasks					
c. takes direction					
d. behavioral reaction to criticism					
e. interacts in a socially appropriate way					
displays regard for safety practices and procedures					
maintains attention to job tasks (i.e. distractability)					
displays acceptable behavior in peer interaction on job					

		0	1.	2.	3.	4.
7.	JOB MAINTENANCE BEHAVIORS (continued)					
	dresses in accordance with job demands					
	production quality					
	production quantity					
	other (specify)					
8.	WORK ENVIRONMENT STRESSORS					
	Behavioral reaction to:					
	a. physical/chemical environment					
	b. psychological environment					
	c. cultural/social environment					
	d. other (specify)					
C.	LEISURE ACTIVITIES					
1.	OBSERVED OR REPORTED LEISURE TIME ACTIVITIES IN:					
	a. reading					
	b. television					
	c. radio					
	d. group sports participation					
	e. physical exercise (jogging, etc.)					
	f. hobbies					
	g. church (or religious) group participation					
	h. clubs/social organiations participation					
	i. other (specify)					

C. LESIURE ACTIVITIES (continued)	0	1.	2.	3.	4.
2. ACCESS TO SOCIAL GROUPS					
3. ALCOHOL USAGE					
4. RECREATIONAL DRUG USAGE					
5. OBSERVED OR REPORTED SATISFACTION WITH LEISURE ACTIVITIES					
6. OTHER (SPECIFY)					
D. SOCIAL/INTERPERSONAL					
1. FAMILY ENVIRONMENT					
encouragement by family for community involvement					
client dependence on family:					
a. economically					
b. psychologically					
c. socially					
obseved or reported effect of family:					
a. economically					
b. psychologically					
c. socially					
present marital status (specify)					
number of children (specify)					
present living environment (specify)					

D. SOCIAL INTERACTIONS (continued)	0	1.	2.	3.	4.
1. FAMILY ENVIRONMMENT (continued)					
anticipated future living environment (specify)					
other (specify)					
2. PERSONAL INTERACTIONS					
observed or reported ability to cope with the public in:					
a. stores					
b. crowds					
c. restaurants					
d. schools					
e. other (specify)					
f. other (specify)					
observed or reported social supports (i.e. friends)					
observed or reported interpersonal behavior concerning:					
a. expressing affect					
b. giving feedback					
c. receiving feedback					
d. expressing sexuality					
e. empathy for others					
f. withdrawal from others					
g. violence (expressed or implied) with others					

	0	1.	2.	3.	4.
h. friendliness toward others					
i. other (specify)					
j. other (specify)					
D. SOCIAL INTERACTIONS (continued)					
3. COMMUNITY INTERACTIONS					
use of community resources					
a. vocational					
b. legal					
c. psychotherapeutic					
d. medical					
e. previous use (admission, service consumption, etc.) of this resource					
4. ECONOMIC SITUATION					
source(s) of support (specify)					
incentives to work					